SERFF Tracking Number:	*WKLY-125992407*	*State:*	*Arkansas*
Filing Company:	*Sterling Investors Life Insurance Company*	*State Tracking Number:*	*41357*
Company Tracking Number:	*SI AR CC REV APP*		
TOI:	*H13I Individual Health - Short Term Care*	*Sub-TOI:*	*H13I.002 Nursing Home*
Product Name:	*SI AR CC Rev App*		
Project Name/Number:	*/*		

Filing at a Glance

Company: Sterling Investors Life Insurance Company

Product Name: SI AR CC Rev App	SERFF Tr Num: WKLY-125992407	State: ArkansasLH
TOI: H13I Individual Health - Short Term Care	SERFF Status: Closed	State Tr Num: 41357
Sub-TOI: H13I.002 Nursing Home	Co Tr Num: SI AR CC REV APP	State Status: Approved-Closed
Filing Type: Form	Co Status:	Reviewer(s): Rosalind Minor
	Author: Karen Nowlan	Disposition Date: 01/16/2009
	Date Submitted: 01/16/2009	Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name:	Status of Filing in Domicile: Pending
Project Number:	Date Approved in Domicile:
Requested Filing Mode:	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Group Market Size:
Overall Rate Impact:	Group Market Type:
Filing Status Changed: 01/16/2009	
State Status Changed: 01/16/2009	Deemer Date:

Corresponding Filing Tracking Number:

Filing Description:

Revised Application

Company and Contact

Filing Contact Information

(This filing was made by a third party - WAI01)

Karen Nowlan, Compliance Analyst	karen.nowlan@wakelyinc.com

SERFF Tracking Number:	*WKLY-125992407*	*State:*	*Arkansas*
Filing Company:	*Sterling Investors Life Insurance Company*	*State Tracking Number:*	*41357*
Company Tracking Number:	*SI AR CC REV APP*		
TOI:	*H13I Individual Health - Short Term Care*	*Sub-TOI:*	*H13I.002 Nursing Home*
Product Name:	*SI AR CC Rev App*		
Project Name/Number:	*/*		

Wakely and Associates, Inc.
Largo, FL 33773-1502
(727) 584-8128 [Phone]
(727) 584-5613[FAX]

Filing Company Information

Sterling Investors Life Insurance Company
210 E. Second Avenue, Suite 105
Rome, GA 30161
(706) 235-8154 ext. [Phone]

CoCode: 89184
Group Code: -99
Group Name:
FEIN Number: 59-1838073

State of Domicile: Georgia
Company Type: Life and Health
State ID Number:

SERFF Tracking Number:	*WKLY-125992407*	*State:*	*Arkansas*
Filing Company:	*Sterling Investors Life Insurance Company*	*State Tracking Number:*	*41357*
Company Tracking Number:	*SI AR CC REV APP*		
TOI:	*H13I Individual Health - Short Term Care*	*Sub-TOI:*	*H13I.002 Nursing Home*
Product Name:	*SI AR CC Rev App*		
Project Name/Number:	*/*		

Filing Fees

Fee Required?	Yes
Fee Amount:	$20.00
Retaliatory?	No
Fee Explanation:	1 form (application) X $20 = $20
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Sterling Investors Life Insurance Company	$20.00	01/16/2009	25075042

SERFF Tracking Number:	*WKLY-125992407*	*State:*	*Arkansas*
Filing Company:	*Sterling Investors Life Insurance Company*	*State Tracking Number:*	*41357*
Company Tracking Number:	*SI AR CC REV APP*		
TOI:	*H13I Individual Health - Short Term Care*	*Sub-TOI:*	*H13I.002 Nursing Home*
Product Name:	*SI AR CC Rev App*		
Project Name/Number:	*/*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	01/16/2009	01/16/2009

SERFF Tracking Number:	*WKLY-125992407*	*State:*	*Arkansas*
Filing Company:	*Sterling Investors Life Insurance Company*	*State Tracking Number:*	*41357*
Company Tracking Number:	*SI AR CC REV APP*		
TOI:	*H13I Individual Health - Short Term Care*	*Sub-TOI:*	*H13I.002 Nursing Home*
Product Name:	*SI AR CC Rev App*		
Project Name/Number:	*/*		

Disposition

Disposition Date: 01/16/2009
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*WKLY-125992407*	*State:*	*Arkansas*
Filing Company:	*Sterling Investors Life Insurance Company*	*State Tracking Number:*	*41357*
Company Tracking Number:	*SI AR CC REV APP*		
TOI:	*H13I Individual Health - Short Term Care*	*Sub-TOI:*	*H13I.002 Nursing Home*
Product Name:	*SI AR CC Rev App*		
Project Name/Number:	*/*		

Item Type	Item Name	Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	Certification	Approved-Closed	Yes
Supporting Document	NAIC TRANSMITTAL	Approved-Closed	Yes
Form	Application	Approved-Closed	Yes

SERFF Tracking Number:	*WKLY-125992407*	*State:*	*Arkansas*
Filing Company:	*Sterling Investors Life Insurance Company*	*State Tracking Number:*	*41357*
Company Tracking Number:	*SI AR CC REV APP*		
TOI:	*H13I Individual Health - Short Term Care*	*Sub-TOI:*	*H13I.002 Nursing Home*
Product Name:	*SI AR CC Rev App*		
Project Name/Number:	*/*		

Form Schedule

Lead Form Number: SI CCAPP200901AR

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	SI CCAPP200901AR	Application/ Enrollment Form	Application	Revised	Replaced Form #: SI CC APP 01/06AR Previous Filing #: SERT−6KHTRL500/00		SI CC APP 200901AR.pdf

STERLING INVESTORS LIFE INSURANCE COMPANY

Home Office: Rome, Georgia
Administrative Office: P.O. Box 10846, Clearwater, Florida 33757-8846

CONVALESCENT CARE INSURANCE POLICY APPLICATION

APPLICANT

Last *First* *MI*

AGE	DATE OF BIRTH			SEX
	Month	*Day*	*Year*	☐ Male ☐ Female

SOCIAL SECURITY NUMBER

RESIDENCE ADDRESS

Street:

City:

State: *Zip Code*

Area Code: *Telephone Number:*

Underwriting Risk Classification Question
Have you used any form of tobacco in the past five years? ☐ Yes ☐ No

BENEFIT OPTIONS

☐ **Convalescent Care Insurance Policy**

Maximum Daily Benefit Amount **$**_____

Maximum Benefit Period ☐ **180 Days** ☐ **360 Days**

Optional Riders

☐ **In Home Convalescent Care Rider**

☐ **Compound Inflation Protection Rider**

HEALTH QUESTIONS

IF YOU ANSWER "YES" TO ANY OF THE HEALTH QUESTIONS, YOU ARE NOT ELIGIBLE FOR COVERAGE.

1.	Do you require assistance or supervision of any kind to perform activities of daily living such as walking, eating, bathing, dressing, transferring or toileting?	☐ Yes	☐ No
2.	Do you require assistance with shopping, housekeeping or cooking?	☐ Yes	☐ No
3.	During the past two (2) years have you:		
	(a) been a resident of an assisted living facility or personal care home or been confined to a nursing home, home for the aged, or any facility providing assistance with activities of daily living?	☐ Yes	☐ No
	(b) required any assistance with mobility including the use of a walker, single cane, quad cane, walking aids, wheelchair, or scooter?	☐ Yes	☐ No
4.	Are you bedridden?	☐ Yes	☐ No
5.	Are you currently hospitalized or have you been hospitalized two or more times within the past year?	☐ Yes	☐ No
6.	Within the past two years, have you been advised to have kidney dialysis?	☐ Yes	☐ No
7.	Within the past two years, have you had a heart attack, stroke or heart valve surgery?	☐ Yes	☐ No
8.	Within the past two years, have you had or been treated for internal cancer, leukemia or malignant melanoma, Hodgkin's Disease, Parkinson's Disease, disabling arthritis, degenerative bone disease, cirrhosis of the liver, Alzheimer's Disease or alcohol or drug abuse?	☐ Yes	☐ No
9.	Within the past two years, have you been recommended to have surgery for cataracts, joint replacement, a heart condition or other in-patient surgery but not had such surgery?	☐ Yes	☐ No
10.	Have you had or been told by your physician you have emphysema, chronic bronchitis, other chronic lung disease, Myasthenia Gravis, Lupus, Multiple or Amyotrophic Lateral Sclerosis, paralysis, Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?	☐ Yes	☐ No
11.	Have you had or been told by your physician you needed amputation due to disease?	☐ Yes	☐ No
12.	Are you an insulin dependent diabetic?	☐ Yes	☐ No

Effective Date:	***Special Requests:***

PLEASE SELECT THE METHOD OF PAYMENT YOU WANT

☐ Bank Draft ☐ Annual ☐ Semiannual ☐ Quarterly ☐ Monthly Bank Draft

PREMIUM CALCULATION

CONVALESCENT CARE ONLY PREMIUM	**$**
IN HOME CONVALESCENT CARE RIDER PREMIUM	**$**
COMPOUND INFLATION PROTECTION RIDER PREMIUM	**$**
SUBTOTAL	**$**
LESS SPOUSAL DISCOUNT (IF APPLICABLE)	**$**
TOTAL PREMIUM PAID WITH APPLICATION	**$**

REPLACEMENT INFORMATION (MUST BE COMPLETED)

1. Do you have another insurance policy in force (including health care service contract or health maintenance organization contract)? ☐ Yes ☐ No

2. Did you have another limited benefit policy in force during the last six (6) months? ☐ Yes ☐ No

   If yes, with which company: (Name and address): _____

   _____

Policy Number: _____ If that policy lapsed, when did it lapse? _____

Daily Benefit Amount: $_____ Benefit Period _____

Do you intend to replace any of your medical or health insurance coverage with this policy? ☐ Yes ☐ No

If yes, please read and sign the replacement notice provided by the agent.

AUTHORIZATION AND CERTIFICATION

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager or other medical facility, insurance or reinsurance company, Medical Information Bureau (MIB), consumer reporting agency, Division of Motor Vehicles, the Veterans Administration or other medical or medically-related facility, insurance company or other organization, institution or person including Medicare, that has any records or knowledge of me or my health or having any non-medical information concerning me to give Sterling Investors Life Insurance Company, or its reinsurers, any such information. I understand that I am authorizing Sterling Investors Life Insurance Company to receive my health information, prescription drug usage history and my non-medical information. The released information received by Sterling Investors Life Insurance Company will remain protected by federal and/or state regulations as long as it is maintained by the health plan. Any information that is disclosed pursuant to this authorization may be redisclosed as provided herein or as required or authorized by law and may then no longer be covered by federal rules governing privacy and confidentiality of health information.

I understand that the information requested is necessary for evaluation and underwriting of my application for the insurance policy for which I have applied; to determine eligibility for insurance, risk rating or policy issue determinations; obtain reinsurance; administer claims and determine or fulfill responsibility for coverage and provision of benefits; and to conduct other legally permissible activities that relate to any coverage I have, or have applied for, with Sterling Investors Life Insurance Company. I understand that telephone interviews may be a part of the application process and that any information obtained from such telephone interviews may be used to decline my application for coverage. I understand that failure to provide the authorization to Sterling Investors Life Insurance Company *will* result in the rejection of the insurance policy coverage. I understand that I may revoke this authorization at any time by notifying Sterling Investors Life Insurance Company in writing at their Administrative Office: P.O. Box 10846, Clearwater, Florida 33757-8846. I understand that such revocation will not have any effect on actions Sterling Investors Life Insurance Company took prior to their receiving the revocation notice. I understand that this authorization will be valid for twenty-four (24) months from the date signed if used in connection with an application for an insurance policy, reinstatement of an insurance policy, change in policy benefits; or for the duration of a claim if used for the purpose of collecting information with a claim for benefits under a policy. A photocopy of this authorization will be treated in the same manner as the original.

To the best of my knowledge and belief, all of the answers to the questions contained in this application are true and complete and I understand and agree that: (a) the insurance shall not take effect unless and until the application has been accepted and approved by the Company, the full first premium has been paid, and the policy has been delivered to the applicant; and (b) oral statements between the agent and myself are not binding on the Company unless accepted by the Company in writing. The undersigned applicant certifies that the applicant has read, or had read to him, the completed application and that he realizes that any false statements or misrepresentations therein material to the risk may result in loss of coverage under the policy to which this application is a part. I understand that any change in my health history prior to delivery of this policy may be used in the underwriting evaluation process.

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT T FINES AND CONFINEMENT IN PRISON.

I acknowledge receiving an outline of coverage for the policy applied for.

Signed At: _____
(City /State)

Dated: _____ Applicant's Signature:_____
(Month/Day/Year)

AGENT'S CERTIFICATION

The undersigned Agent certifies that the Applicant has read, or has had read to them, the completed application and that the Applicant realizes that any false statement or misrepresentation in the application may result in loss of coverage under the policy.

TO BE COMPLETED BY AGENT (Attach separate sheet, if necessary)

1. List any other health insurance policy you have sold to the Applicant that is still in force.

_____
_____
_____
_____

2. List any other health insurance policy you have sold to the Applicant in the past five (5) years that is no longer in force.

_____
_____
_____
_____

I certify that:

1. I have accurately recorded the information supplied by the Applicant; and
2. I have given an outline of coverage for the policy applied for to the Applicant.

Agent's Signature	Date
Agent's Printed Name	Agent Number

SERFF Tracking Number:	*WKLY-125992407*	*State:*	*Arkansas*
Filing Company:	*Sterling Investors Life Insurance Company*	*State Tracking Number:*	*41357*
Company Tracking Number:	*SI AR CC REV APP*		
TOI:	*H13I Individual Health - Short Term Care*	*Sub-TOI:*	*H13I.002 Nursing Home*
Product Name:	*SI AR CC Rev App*		
Project Name/Number:	*/*		

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number:	*WKLY-125992407*	*State:*	*Arkansas*
Filing Company:	*Sterling Investors Life Insurance Company*	*State Tracking Number:*	*41357*
Company Tracking Number:	*SI AR CC REV APP*		
TOI:	*H13I Individual Health - Short Term Care*	*Sub-TOI:*	*H13I.002 Nursing Home*
Product Name:	*SI AR CC Rev App*		
Project Name/Number:	*/*		

Supporting Document Schedules

Satisfied -Name: Flesch Certification
Review Status: Approved-Closed 01/16/2009
Comments:
Attachment:
Flesch Cert .pdf

Bypassed -Name: Application
Review Status: Approved-Closed 01/16/2009
Bypass Reason: See Form Schedule
Comments:

Bypassed -Name: Health - Actuarial Justification
Review Status: Approved-Closed 01/16/2009
Bypass Reason: NA
Comments:

Bypassed -Name: Outline of Coverage
Review Status: Approved-Closed 01/16/2009
Bypass Reason: NA
Comments:

Satisfied -Name: Certification
Review Status: Approved-Closed 01/16/2009
Comments:
Attachment:
AR Certificate of Compliance.pdf

Satisfied -Name: NAIC TRANSMITTAL
Review Status: Approved-Closed 01/16/2009
Comments:
Attachment:
AR NAIC TRANSMITTAL.pdf

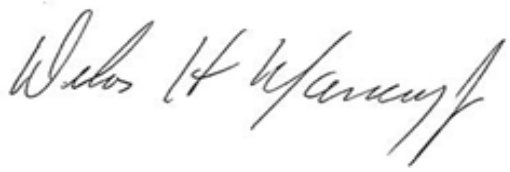
READABILITY COMPLIANCE CERTIFICATION

Name and Address of Insurer:

Sterling Investors Life Insurance Company
Rome Georgia

I hereby certify that the Flesch Reading Ease Test Score for form number SI CCAPP200901AR meets the minimum reading ease score required by ACA 23-80-206.

Signed for the Company by an Officer



President

Date: January 9, 2009

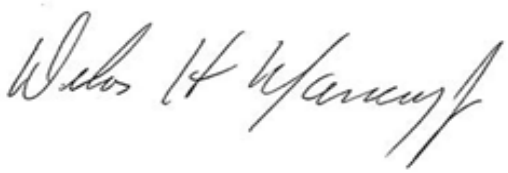
ARKANSAS COMPLIANCE CERTIFICATION

Name and Address of Insurer:

Sterling Investors Life Insurance Company
Rome Georgia

The Company has reviewed the enclosed policy forms and certifies that, to the best of its knowledge and belief, each form submitted complies with the requirements of Rules and Regulation 19; Rule and Regulation 49, and ACA 23-79-138 and Bulletin 11-88.

Signed for the Company by an Officer



President

Date: January 9, 2009

Effective January 1, 2009

Reset Form

Life, Accident & Health, Annuity, Credit Transmittal Document

1.	Prepared for the State of	Arkansas

2.	Department Use Only
	State Tracking ID

3.	Insurer Name & Address	Domicile	Insurer License Type	NAIC Group #	NAIC #	FEIN #	State #
	Sterling Investors Life Insurance Co 210 E Second Ave Ste 105 Rome Georgia 30161	Georgia	LH, AH		89194	59-1838073	

4. Contact Name & Address	Telephone #	Fax #	E-mail Address
Karen Nowlan Wakely and Associates Inc 8545 126th Ave N Suite 200 Largo FL 33773-1502	727-584-8128, ext 2171	727-584-5613	Karen.Nowlan@iasadmin.com

5.	Requested Filing Mode	☑ Review & Approval ☐ File & Use ☐ Informational ☐ Combination (please explain): _____ ☐ Other (please explain): _____

6.	Company Tracking Number	WKLY-125992407
7.	☑ New Submission ☐ Resubmission	Previous file # _____
8.	Market	☑ Individual ☐ Franchise Group: ☐ Small ☐ Large ☐ Small and Large ☐ Employer ☐ Association ☐ Blanket ☐ Discretionary ☐ Trust ☐ Other: _____
9.	Type of Insurance	**H13I Individual Health-Short Term Care**
10.	Product Coding Matrix Filing Code	**H13I.002 Nursing Home**
11.	Submitted Documents	☐ **FORMS** ☐ Policy ☐ Outline of Coverage ☐ Certificate ☑ Application/Enrollment ☐ Rider/Endorsement ☐ Advertising ☐ Schedule of Benefits ☐ Other **Rates** ☐ New Rate ☐ Revised Rate ☐ **FILING OTHER THAN FORM OR RATE:** Please explain: _____ **SUPPORTING DOCUMENTATION** ☐ Articles of Incorporation ☑ Third Party Authorization ☐ Association Bylaws ☐ Trust Agreements ☐ Statement of Variability ☐ Certifications ☐ Actuarial Memorandum ☐ Other_____

12.	**Filing Submission Date**	01/16/2009
13	**Filing Fee (If required)**	Amount $20 Check Date EFT Retaliatory ☐ Yes ☑ No Check Number EFT
14.	**Date of Domiciliary Approval**	Pending

15. Filing Description:

We have been authorized by Sterling Investors Life Insurance Company to file the attached revised application on their behalf. A letter of authorization is included with this filing.

The revised Application will replace SI CC APP 01/06AR (SERFF TR# SERT−6KHTRL500/00) which was approved by your Department on 07/27/2006 The following changes were made to the application:

1) The Authorization and Reason for Disclosure sections were revised and combined into one section;
2) HIPAA required language regarding re-disclosure of information was added to the Authorization section;
3) The insurance company's name was added to the footer.

Thank you for your assistance with this submission.

View Complete Filing Description

16. Certification (If required)

I HEREBY CERTIFY that I have reviewed the applicable filing requirements for this filing, and the filing complies with all applicable statutory and regulatory provisions for the state of ARKANSAS.

Print Name Karen Nowlan Title Compliance Analyst

Signature Karen Nowlan Digitally signed by Karen Nowlan DN: cn=Karen Nowlan, o=Wakely and Associates, Inc, ou=Compliance, email=Karen.Nowlan@Wakelyinc.com, c=US Date: 2009.01.16 08:21:45 -05'00' Date: 01/16/2009

17.	Form Filing Attachment
This filing transmittal is part of company tracking number	WKLY-125992407
This filing corresponds to rate filing company tracking number	

	Document Name / Description	Form Number		Replaced Form Number / Previous State Filing Number
01	Application	SI CCAPP200901AR	☐ Initial ☑ Revised ☐ Other _____	SI CC APP 01/06AR SERT-6KHTRL500/00
02			☐ Initial ☐ Revised ☐ Other _____	
03			☐ Initial ☐ Revised ☐ Other _____	
04			☐ Initial ☐ Revised ☐ Other _____	
05			☐ Initial ☐ Revised ☐ Other _____	
06			☐ Initial ☐ Revised ☐ Other _____	
07			☐ Initial ☐ Revised ☐ Other _____	
08			☐ Initial ☐ Revised ☐ Other _____	
09			☐ Initial ☐ Revised ☐ Other _____	
10			☐ Initial ☐ Revised ☐ Other _____	

LH FFA-1

18.	Rate Filing Attachment			
This filing transmittal is part of company tracking number				
This filing corresponds to form filing company tracking number				
Overall percentage rate indication (when applicable)				
Overall percentage rate impact for this filing			**%**	
	Document Name **Description**	**Affected Form Numbers**		**Previous State Filing Number**
01			☐ **New** ☐ **Revised** **Request +____% -____%** ☐ **Other _____**	
02			☐ **New** ☐ **Revised** **Request +____% -____%** ☐ **Other _____**	
03			☐ **New** ☐ **Revised** **Request +____% -____%** ☐ **Other _____**	
04			☐ **New** ☐ **Revised** **Request +____% -____%** ☐ **Other _____**	
05			☐ **New** ☐ **Revised** **Request +____% -____%** ☐ **Other _____**	
06			☐ **New** ☐ **Revised** **Request +____% -____%** ☐ **Other _____**	
07			☐ **New** ☐ **Revised** **Request +____% -____%** ☐ **Other _____**	
08			☐ **New** ☐ **Revised** **Request +____% -____%** ☐ **Other _____**	
09			☐ **New** ☐ **Revised** **Request +____% -____%** ☐ **Other _____**	
10			☐ **New** ☐ **Revised** **Request +____% -____%** ☐ **Other _____**	

LH RFA-1

